# PART 10
# MEDICALLY NEEDY ELIGIBILITY CRITERIA

If eligibility does not exist as Categorically Needy, an assistance unit may still gain eligibility through Medically Needy even if assets exceed the Categorically Needy asset limit, or countable income exceeds the appropriate Federal Poverty Level (FPL) (See Chart 6).

The asset and income limits for Medically Needy are used to determine eligibility.

**Note:** Budgeting for Categorically Needy and Medically Needy are the same.

## SECTION 1 MEDICALLY NEEDY ASSET LIMITS

Assets can be under the following limits on any day of the month to be eligible for that month.

I. For Family - Related coverage groups:

The maximum amount of countable assets an individual or assistance unit may retain for Medically Needy eligibility is:

$2,000 for one person
$3,000 for two persons
$ 100 for each additional person

To determine the appropriate assistance unit size, whose assets will be counted, and the asset limit:

A. Count all people who will be covered.
B. Add in the child(ren)'s legal parent(s) in the home, even if they are not to be covered unless they receive TANF or SSI.

II. For SSI - Related coverage groups:

$2000 for an individual not married or not living with a spouse, Including an individual who is a child.

$3000 for an eligible couple or an individual living with an ineligible spouse

## SECTION 2 MEDICALLY NEEDY INCOME LIMITS

For Family – Related coverage groups: the income limit is the Protected Income Level (PIL) based on the assistance unit size as determined in Part 4, Section 3.1.

For SSI - Related coverage groups:

I. Medically Needy Coverage for an Individual -
If an individual is not Medicaid eligible under Categorically Needy, the Protected Income Level (PIL) for one (see Chart 5) is deducted from

the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

II. Medically Needy Process in Deeming to an Eligible Child -
If the child is not eligible under Categorically Needy, then the Protected Income Level (PIL) for one (see Chart 5) is deducted from the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

III. Medically Needy Coverage for a Couple -
If the couple or eligible individual with an ineligible spouse is not Medicaid eligible as Categorical Needy, the Protected Income Level (PIL) for two (see Chart 5) is deducted from the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

## SECTION 3 MEDICALLY NEEDY DEDUCTIBLE PROCESS

Individuals who are ineligible under Categorically Needy and whose income is above the appropriate Protected Income Level (PIL) are not eligible for Medicaid until they meet a deductible. This deductible is met by applying incurred costs for necessary medical services as outlined below.

The deductible is determined as follows:

I. Determine the countable income.

II. Subtract the PIL for the appropriate assistance unit size (See Chart 5).

III. Multiply by the number of months in the eligibility period (usually six months) (See Part 2, Section 13.2).

The result is the deductible amount for the eligibility period.

Before opening coverage at any time during the eligibility period, the worker must review and update the deductible amount. If there are any changes in income (use actual income received where possible), assistance unit composition or Protected Income Levels, a new deductible amount will be figured.

To be applied to the deductible, bills must be submitted within one year of the date of application.

If the deductible is met using medical costs that are not covered under Medically Needy, the individual will become eligible as of the first day of the eligibility period. Otherwise, coverage will begin when the deductible is met.

Once the deductible is met and eligibility begins, bills for a coverable service may be submitted that could have been used to meet the deductible. These bills will be covered if they are submitted within one year of the date of the eligibility decision.

## SECTION 4 APPLICABLE MEDICAL COSTS

The cost of necessary medical services for individuals in the assistance unit and for individuals whose income or assets are or would be used in determining eligibility may be applied against the deductible.

For individuals who are included in more than one assistance unit, the cost of necessary medical services can be applied toward each deductible.

When an individual has sufficient costs to meet the deductible, but an accurate start date cannot be determined due to missing bills or pending insurance payments, begin eligibility for the first full month. Back date eligibility when all information is provided.

**Example:**

- Deductible time period June through November. Deductible amount $3600.
- $5000 in applicable medical costs are received that would result in individual meeting the deductible August 15th. However, an additional $2000 in medical costs incurred prior to August 15th are pending third party insurance payments.
- Open coverage effective September 1st.
- Once the additional $2000 in medical costs has been adjusted by the third party insurance payments, the start of coverage prior to September 1st will be determined.

Medical costs are applied in the following order:

I. Verified medical insurance premiums, including Medicare.

**Note**: Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition (such as cancer) but not for a specific service.

II. Verified actual costs incurred during the eligibility period for medical or remedial care costs not covered under Medicaid such as eyeglasses, dental services and hearing aides for individuals over age 21.

III. Medical costs incurred during the eligibility period by individuals who are part of the assistance unit but not eligible for coverage (such as an ineligible spouse or deeming parent in an SSI - Related unit or the parents of an individual whose eligibility is based on being under age 21).

IV. The unpaid balance on a loan taken out to pay for an old medical bill which was incurred prior to the eligibility period provided:
    A. The proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the old medical bill may be deducted. Any portion used for another purpose may not be deducted.
    B. Neither the medical bill nor the unpaid balance of the loan were previously applied against another deductible.
    C. Only the principal part of the unpaid balance may be used in the deductible - not the interest.

This provision allows the individual to use the liability to the lender in place of the liability to the provider.

V. Medical costs incurred prior to the eligibility period and not applied toward another deductible, and which are unpaid on the first day of the eligibility period, which resulted in eligibility.

**Example:**
Individual has a medical bill of $5000. He has a deductible for January through June of $4500. He meets the deductible and in July incurs another $4500 deductible. The $500 remaining from the $5000 medical bill can be used towards the new deductible.

VI. Additional services or items necessary for medical treatment such as transportation, long distance telephone calls to medical providers, cost of lodging to receive treatment away from home and nonprescription items or drugs incurred during the eligibility period.

VII. Medicaid coverable costs, paid or unpaid, incurred during the eligibility period in order of service date, including the following medical costs:
   A. Medical costs incurred during the eligibility period as long as they have not been written off by the provider during the eligibility period.
   B. Medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

Once the deductible has been met, the eligible individuals in the assistance unit will be eligible for Medicaid for the remainder of the eligibility period or until information is provided which would change the eligibility.

## SECTION 5 NON-APPLICABLE MEDICAL COSTS

The following types of medical bills cannot be considered toward a deductible:

I. Medical costs incurred and paid prior to the eligibility period.

II. Portions of medical costs applied toward a previous deductible, if the deductible is met.

III. Portions of medical costs paid by insurance, including Medicare adjustments.

IV. Medical costs paid by individuals or groups outside the assistance unit for which the individual has no obligation to repay. The exception is medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

V. Medical costs incurred by individuals who are not members of the assistance unit and whose income and assets are not used in determining eligibility.

VI. Payments on old medical bills incurred prior to the eligibility period.

VII. Medical costs incurred during a penalty period.

VIII. Unpaid costs of care to a medical institution or waiver agency during periods of eligibility.

**Example:**
This example shows how medical expenses are applied to a deductible and the order in which they must be applied.

An individual, age 22, determined disabled in April, submits the following bills to meet a deductible of $3820 for April through September.

Determine that there are no changes to the deductible amount and that all of the bills submitted can be used toward the current remaining deductible:

Total Deductible:
$3820.00

1. Medical Insurance premium ($79.05 monthly X 6) - $ 474.30
   Remaining deductible
   $3345.70

2. Items not covered by Medicaid
   Eyeglasses (purchased 4/12) - $ 125.00
   Remaining deductible
   $3220.70

3. Old unpaid medical bills
   Doctor's statement shows an outstanding balance as of 3/31 of $650.00 - $ 650.00
   Remaining deductible
   $2570.70

4. Medicaid coverable costs paid or unpaid incurred During the eligibility period

   The hospital bill for 4/3 through 4/6 ($3500) was not itemized for insurance payments ($1200). To determine the daily portion of the hospital bill the client is responsible for - divide the total insurance payment by the total hospital bill to the 4th decimal place ($1200 ÷ $3500 = .3428).

   4/3 Charges
   Multiply 4/3 hospital bill by .3428 ($1500 x .3428 = $514.20)

Subtract the result from the 4/3 hospital bill
($1500 – $514.20 = $985.80)

4/3 hospital charge used against the deductible - $ 985.80
Remaining deductible
$1584.90

4/4 Charges
Multiply 4/4 hospital bill by .3428 ($1000 x .3428 = $342.80) Subtract the result from the 4/4 hospital bill
($1000 – $342.80 = $657.20) $ 657.20
Physician's bill after insurance + $ 65.00
Prescription + $ 46.25
Total charges for 4/4 - $ 768.45
Remaining deductible $ 816.45

4/5 Charges
Multiply 4/5 hospital bill by .3428 ($900 x .3428 = $308.52)
Subtract the result from the 4/5 hospital bill
($1000 – 308.52 = $691.48) $ 691.48
Physician's bill after insurance + $ 200.00
Radiology services after insurance + $ 400.00
Total charges for 4/5
$1291.48

The charges for 4/5 are greater than the remaining deductible of $816.45.

The applicant met the deductible on 4/5. The first full day of coverage is 4/6.

The applicant is responsible for the remaining deductible of $816.45 and there are a number of bills on 4/5. There is a manual process to distribute the applicant's responsibility to each provider.

To determine the applicant share for each provider for bills incurred on 4/5:

1. Divide remaining deductible by total charges for 4/5 to the 4th decimal place. ($816.45 ÷ $1291.48 = .6322)

2. Multiply each provider's bill by .6322. This is the amount the applicant is responsible for.

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|---|---|---|---|---|
| Hospital | $691.48 x | .6322 | = | $437.13 |
| Physician | $200.00 x | .6322 | = | $126.44 |
| Radiology | $400.00 x | .6322 | = | $252.88 |
| | | | | |
| Applicant responsibility for 4/5 | | | | $816.45 |

**Notes:**
When a hospital bill covers more than one day, a notice is sent to the applicant and the hospital. The notice includes the total bill from admit to discharge and of that amount the total the applicant is responsible for.

If medical bills are received for a period prior to the date the deductible was met, but between the first date of eligibility and the Medicaid eligibility date, a notice will be sent to the client and provider showing a zero responsibility for the client.

## SECTION 6 VERIFICATION OF MEDICAL COSTS

All costs applied to the deductible must be verified. For each item, with the exception of transportation costs, the applicant must provide a dated bill or receipt showing the name of the provider, date of service, type of service, costs and any insurance payments. If the applicant does not provide an appropriate bill or receipt, the cost cannot be applied.

For transportation, the individual's record must show the reason the cost was incurred, the place visited and the date. A receipt is required if the applicant paid someone else for the transportation. If the applicant's car was used, the actual cost of gas and oil may be calculated or a mileage cost allowed (using current allowance authorized by State Employees Contract). The individual should be given the opportunity to choose whichever option they prefer.